OTOLARYNGOLOGY
HEAD & NECK SURGERY

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IMPORTANT NOTICE TO OUR PATIENTS

Due to the many changes in health care, it has become necessary for our office to adopt the following policies:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

1. All patients with managed care policies are required to pay their appropriate co-pay **at the time of service**. It is your responsibility to know your insurance: If a referral form is needed, if pre-certification is required, etc. A telephone will be made available for your use if needed to call your benefit department.

2. All patients with non-managed care insurance will be billed for any balance after we receive payment from your insurance company. If you have a co-pay, you will be required to pay the appropriate amount at the time of service.

3. All patients with traditional **Indemnity** policies (non-managed care) or no insurance will be responsible for the balance in full at the time of service.

4. **Collection Policy**: In the event that your account is uncollectable, you will be charged an interest rate of 1.5% per month and all legally allowable fees including, but not limited to court costs, legal fees and penalties.

Protect your insurance benefits! During the past few years, the number of insurance companies has increased at an amazing rate. Even within one company there may be dozens of different programs with varying benefits and requirements. There is no way we can know or keep up with your employer's benefit program, which are often custom designed. It must be your responsibility to know and advise us of your program requirements.

Please understand that if we provide a service that you know or should have known was uncovered, you will be held responsible for payment.

Please be advised that I _____ authorize payment to be made directly to **Otolaryngology Head & Neck Surgery**.

Patient Signature _____

Witness _____

Patient's or authorized person's signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed _____ date _____

Patient signature _____ date _____